CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 10, 2000

H.R. 3655
Improved Medical Care for Troops and Retirees Act

As introduced on February 15, 2000

SUMMARY

H.R. 3655 contains several provisions to improve health care benefits for current and former military personnel and their families. The bill would change the current demonstration project of Medicare subvention to a permanent, nationwide program, and it would extend another demonstration project that offers retirees and their dependents coverage under the Federal Employee Health Benefits Program (FEHB). It would eliminate fees, deductibles, and copayments for dependents of certain personnel on active duty in remote locations. Similarly, H.R. 3655 would waive copayments under Tricare Prime for dependents of personnel on active duty. The bill would also improve pharmacy benefits and other aspects of health programs of the Department of Defense (DoD).

CBO estimates that implementing the bill would cost roughly $150 million in 2001 and about $1.3 billion over the 2001-2005 period, assuming appropriation of the necessary amounts. Enacting the bill also would raise direct spending by about $20 million in 2001, by about $300 million over the 2001-2005 period, and by about $1 billion over the 2001-2010 period. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

H.R. 3655 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would not affect the budgets of state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 3655 is shown in Table 1. The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), and 050 (national defense).

TABLE 1. ESTIMATED COSTS OF H.R. 3655

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	20	35	62	84	109
Estimated Outlays	0	20	35	62	84	109
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	181	230	292	318	350
Estimated Outlays	0	146	212	273	308	341

Direct Spending

The bill would raise direct spending from provisions on Medicare subvention and health coverage under FEHB. The impact of those provisions on direct spending is shown in Table 2.

Medicare Subvention. DoD provides health care to almost 350,000 retirees and survivors who are over age 64 and eligible for Medicare. This health care is provided at military treatment facilities (MTF) on a space-available basis and includes some services that Medicare does not cover, primarily prescription drugs. Under current law, DoD cannot bill Medicare for the cost of providing health care to those beneficiaries over age 64 except in a demonstration project.

The Congress authorized a demonstration project at up to six sites beginning in January 1998 and ending in December 2000. Under that demonstration, DoD provides care to Medicare-eligible beneficiaries and is reimbursed under certain conditions by the Health Care Financing Administration (HCFA), which administers Medicare. The most important condition is the requirement that DoD maintain a level of effort; any additional care is reimbursable by HCFA up to a cap set in law. This care and reimbursement procedure is known as Medicare subvention.

H.R. 3655 would increase the number of sites where HCFA reimburses DoD for care, would make the demonstration project permanent, and would allow DoD to be reimbursed as a fee-for-service provider instead of the current adjusted HMO rate that DoD now receives. CBO estimates that these provisions would cost $20 million in 2001 and $945 million over the 2001-2010 period.

TABLE 2. ESTIMATED DIRECT SPENDING UNDER H.R. 3655

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
DIRECT SPENDING						
Cost Increases in Medicare						
Spending Under Current Law						
Estimated Budget Authority	195,113	211,518	217,077	234,887	250,997	274,149
Estimated Outlays	195,113	211,518	217,077	234,887	250,997	274,149
Proposed Changes						
Medicare Subvention						
Estimated Budget Authority	0	20	35	55	75	100
Estimated Outlays	0	20	35	55	75	100
FEHB Demonstration Project						
Estimated Budget Authority	0	0	0	1	1	1
Estimated Outlays	0	0	0	1	1	1
Subtotal-Proposed Changes						
Estimated Budget Authority	0	20	35	56	76	101
Estimated Outlays	0	20	35	56	76	101
Spending Under H.R. 3655						
Estimated Budget Authority	195,113	211,538	217,112	234,943	251,073	274,250
Estimated Outlays	195,113	211,538	217,112	234,943	251,073	274,250
Costs of Premium Payments Under FEHB						
Spending Under Current Law						
Estimated Budget Authority	5,012	5,456	5,906	6,352	6,826	7,338
Estimated Outlays	5,012	5,456	5,906	6,352	6,826	7,338
Proposed Changes						
Estimated Budget Authority	0	0	0	6	8	8
Estimated Outlays	0	0	0	6	8	8
Spending Under H.R. 3655						
Estimated Budget Authority	5,012	5,456	5,906	6,358	6,834	7,346
Estimated Outlays	5,012	5,456	5,906	6,358	6,834	7,346
Changes in Direct Spending						
Estimated Budget Authority	0	20	35	62	84	109
Estimated Outlays	0	20	35	62	84	109

In the current subvention demonstration project, enrolled retirees use substantially more care than civilian retirees enrolled in Medicare HMOs. While the high use rate might decline somewhat in a nationwide program, CBO expects that DoD would provide more care to those enrolled in a subvention program relative to the civilian population. Current Medicare-eligible retirees who now receive space-available care at MTFs and choose not to enroll in the subvention program would use the MTFs less frequently. Those retirees would receive more care in the private sector, which would raise costs in the Medicare program.

FEHB Demonstration Program. Under current law, military retirees under the age of 65 are eligible to either enroll in Tricare Prime or to use Tricare's insurance programs (Standard or Extra). Those who use Tricare Standard or Extra may also seek care at MTFs on a space-available basis. Once retirees turn age 65, they are no longer eligible to use the insurance programs, though they may continue to seek care at an MTF when space is available. The same eligibility rules apply to survivors, who are primarily widows and widowers.

Section 3 of H.R. 3655 would extend a current demonstration project by one year—through December 31, 2003—and would allow participants to keep coverage under FEHB after the demonstration program ends. However, H.R. 3655 would not allow enrollment to increase; consequently, this provision would only affect those people currently enrolled in the program. According to DoD, about 2,000 people enrolled by the end of 1999, the only enrollment time permitted under the law. After adjusting for mortality, CBO estimates that this provision would cost about $22 million over the 2001-2005 period and $67 million over 10 years. Extending this provision also would tend to raise Medicare costs because better insurance coverage often leads to greater use of health care services. Because the number of enrollees is small, that increase would be about $1 million a year, beginning in fiscal year 2003.

The government's contribution toward FEHB premiums for beneficiaries under H.R. 3655 would be direct spending because the bill would add an entitlement benefit. The costs of that new entitlement are thus shown as an increase in direct spending.

Spending Subject to Appropriation

Implementing H.R. 3655 would raise discretionary spending by DoD, assuming appropriation of the estimated amounts. The estimated changes in spending subject to appropriation are shown in Table 3.

TABLE 3. ESTIMATED SPENDING SUBJECT TO APPROPRIATION UNDER H.R. 3655

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for the Defense Health Program						
Estimated Authorization Level[a]	16,500	16,500	16,500	16,500	16,500	16,500
Estimated Outlays	16,500	16,500	16,500	16,500	16,500	16,500
Proposed Changes						
Expansion of Pharmacy Program						
Estimated Authorization Level	0	49	87	137	161	189
Estimated Outlays	0	39	77	125	153	181
Reimbursement of Travel Expenses						
Estimated Authorization Level	0	15	23	32	33	34
Estimated Outlays	0	12	21	29	32	34
Copayments Under Tricare Prime						
Estimated Authorization Level	0	38	39	39	39	40
Estimated Outlays	0	31	37	38	39	40
Tricare Prime Remote for Dependents						
Estimated Authorization Level	0	47	49	51	52	54
Estimated Outlays	0	38	46	49	51	53
Reduction of Catastrophic Cap						
Estimated Authorization Level	0	32	32	33	33	33
Estimated Outlays	0	26	31	32	33	33
Subtotal-Proposed Changes						
Estimated Authorization Level	0	181	230	292	318	350
Estimated Outlays	0	146	212	273	308	341
Spending Under H.R. 3655 for the Defense Health Program						
Estimated Authorization Level[a]	16,500	16,681	16,730	16,792	16,818	16,850
Estimated Outlays	16,500	16,646	16,712	16,773	16,808	16,841

a. The 2000 level is the estimated amount appropriated for that year. The current law amounts for the 2001-2005 period assume that appropriations remain at the 2000 level, without adjustment for inflation. If they are adjusted for inflation the base amounts would increase by about $400 million a year, but the estimated changes would remain as shown under "Proposed Changes."

Expansion of Pharmacy Program. Under current law, pharmacy benefits are somewhat limited in scope for military beneficiaries who are eligible for Medicare. Retirees and survivors over age 64 who use MTFs can have their prescriptions filled for free if the MTF pharmacy carries the pharmaceutical products. All beneficiaries over age 64 are eligible, but only retirees who live close to MTFs tend to use this pharmacy benefit intensively.

During the 1990s, many MTFs were closed as a result of base closures. Those beneficiaries over age 64 who lived near an MTF that was closed or who relied on the base to fill prescriptions have additional ways to fill prescriptions, often called the BRAC benefit (where BRAC is short for base realignment and closure). Those retirees can use the military's national mail order pharmacy (NMOP) and have a prescription filled for 90 days for a copayment of $8. If those retirees use a pharmacy in DoD's network they can have a 30-day prescription filled for 20 percent of the network's cost. Retirees who use out-of-network pharmacies are responsible for the full cost of the prescription. The BRAC benefit was created in 1996 and by 1999 about 450,000 people were eligible for it. According to DoD, about one-third of those eligible used the NMOP benefit and filled about 600,000 prescriptions. Eligible beneficiaries also filled a little over 900,000 prescriptions at network pharmacies.

Section 5 of H.R. 3655 would extend the BRAC benefit to all Medicare-eligible beneficiaries over age 64 regardless of where such beneficiaries live. Assuming appropriation of the necessary amounts, CBO estimates that this proposal would cost roughly $580 million over the 2001-2005 period. Although this proposal would apply to all retirees and survivors over age 64, those who currently use MTFs to fill their prescriptions would be unlikely to use the benefit. Having one's prescription filled at an MTF is free, and current users would be unlikely to switch. Beneficiaries with health insurance that covers prescription drugs would be ineligible to participate, though some of those people would likely drop that portion of their health insurance in favor of the BRAC benefit. After adjusting for MTF use patterns, those who already have prescription drug insurance, and those who do not use prescription drugs, CBO estimates that a little more than 360,000 additional people would use the BRAC benefit if H.R. 3655 became law.

CBO used survey data from DoD and information from the Office of Personnel Management on prescription drug use by Medicare-eligible annuitants to estimate how intensively new beneficiaries would use the BRAC benefit. We estimate that usage would initially be low: about two mail-order prescriptions and three network prescriptions per beneficiary in 2001. Because of rising prescription drug prices and increased familiarity with the program, CBO estimates that six mail-order and nine network prescriptions per beneficiary would be filled by 2010.

Reimbursement for Travel Expenses. Under current law, when somebody using the military health system is referred to a new doctor or hospital, the costs of traveling to the new location are paid by the individual. Section 7 of H.R. 3655 would require the Secretary of Defense to reimburse reasonable travel expenses for anybody who had to travel more than 100 miles because of a medical referral. CBO estimates that this provision would apply about 50,000 times each year and that in about one-third of those cases, additional expenses would be incurred for individuals who must accompany the patient. CBO also expects that reimbursements would average about $650 per occurrence, although those costs would rise with inflation. CBO estimates that implementing this proposal would add about $130 million to discretionary outlays over the 2001-2005 period.

Copayments Under Tricare Prime. Under current law, beneficiaries who use MTFs do not need to make any copayments, but beneficiaries enrolled in Tricare Prime, the military health care system's HMO option, are required to make copayments whenever they visit a civilian doctor. In 1999, dependents of active-duty personnel who are enrolled in Tricare Prime saw a civilian doctor about 2.4 million times. H.R. 3655 would eliminate the requirement for those copayments. (Beneficiaries who use Tricare Standard or Extra would still have to pay the applicable co-insurance amounts for each civilian visit.)

CBO estimates that this change would cost $185 million over the 2001-2005 period. Reimbursing Tricare insurance providers for lost revenue would compose about 70 percent of DoD's cost. The remaining 30 percent of the estimated cost results because the lack of cost sharing would likely increase the number of visits to civilian doctors.

Tricare Prime Remote for Dependents. Under current law, personnel on active duty who live far enough away from MTFs are eligible to participate in what DoD calls Tricare Prime Remote. This program allows such personnel to receive care without facing the co-insurance and deductibles that they would otherwise face if they used Tricare Standard, the fee-for-service option. To implement the program, DoD either establishes a network of providers for the active-duty personnel, or it waives the copayments and deductibles when claims are filed under Tricare Standard. In many cases, where the cost of setting up networks is more costly than the cost of waiving such payments, DoD just waives the deductibles and co-insurance.

Section 4 of H.R. 3655 would grant the Tricare Prime Remote benefit to the dependents of personnel on active duty. Using data from DoD, CBO estimates that roughly 67,000 people in these remote locations already use Tricare Standard or Extra. DoD's only cost for those beneficiaries would come from waiving the co-insurance and deductibles. CBO expects that about 3,000 people who do not currently use Tricare insurance would enroll in Tricare Prime Remote because of the lower out-of-pocket costs. Those beneficiaries would cost DoD significantly more per person. In total, CBO estimates that establishing Tricare Prime

Remote for dependents of personnel on active duty would cost about $240 million over the 2001-2005 period.

Reduction of Catastrophic Cap. Under current law, beneficiaries who use Tricare Standard or Extra must pay deductibles and co-insurance up to a cap of $7,500 each year. DoD is responsible for any costs over $7,500. In addition, prior to undergoing surgery at a civilian facility, beneficiaries who use Tricare Standard or Extra and who live close to a MTF must get a signed statement that the surgical procedures the beneficiary is to receive are not available at the MTF. Section 6 of H.R. 3655 would lower this cap from $7,500 to $3,000 per family and would eliminate the need for obtaining nonavailability statements.

CBO estimates that lowering the cap and eliminating nonavailability statements would cost $155 million over the 2001-2005 period; the bulk of the costs would come from lowering the catastrophic cap. CBO estimates that reducing the cap on deductibles and copayments amounts to about $30 million a year, and eliminating nonavailability statements would cost about $2 million per year. Using data from the Medical Expense Panel Survey, conducted by the Department of Health and Human Services, CBO estimates that about 3 percent of the population has out-of-pocket costs greater than $3,000. Applying this to the relevant DoD population, CBO estimates that DoD's costs would rise by an average of just under $2,250 for roughly 14,000 people.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in Table 4. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

TABLE 4. ESTIMATED IMPACT OF H.R. 3655 ON DIRECT SPENDING AND RECEIPTS

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	20	35	62	84	109	125	135	145	150	155
Changes in receipts	Not applicable										

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 3655 contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of state, local, or tribal governments.

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